BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

RACHELLE D. HILLEGEIST	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,052,334
ELLSWORTH CORRECTIONAL FACILITY	)	
Respondent	)	
AND	)	
	)	
STATE SELF-INSURANCE FUND	)	
Insurance Carrier	)	

ORDER

Respondent requested review of the December 4, 2012, Award by Administrative Law Judge Bruce E. Moore. The Board heard oral argument on March 22, 2013, in Wichita, Kansas.

APPEARANCES

R. Todd King, of Wichita, Kansas, appeared for the claimant. E. L. Lee Kinch, of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The Administrative Law Judge (ALJ) found claimant suffered personal injury by accident arising out of and in the course of her employment, and as a result of that injury claimant suffered a 50 percent permanent partial general (work) disability, inclusive of a 5 percent impairment of function to the body as a whole.

Respondent argues that the Award should be reversed as claimant has failed to prove by a preponderance of the credible evidence that she sustained a permanent functional impairment or permanent partial general (work) disability.

Claimant argues the Award should be affirmed in its entirety.

FINDINGS OF FACT

Claimant began working for Larned Correctional Facility on December 5, 2005. She underwent a preemployment physical before beginning this job. Claimant was promoted in September 2007 and on March 23, 2008, she was transferred to work for respondent's Ellsworth Correctional Facility.

Claimant testified that in December 2009 she was a sergeant, Correctional Officer 2, at the Ellsworth Correctional Facility. Claimant alleges that on December 11, 2009, she suffered an accidental injury while performing a fence check around the perimeter during a blizzard. Claimant testified that she tried to stay in the footprints of the officer who did the check during the earlier shift, but it was difficult because the snow was knee deep and every time she took a step she would slip and fall back. On one occasion, as claimant was slipping, she grabbed the fence with her left hand. Her glove ripped and she fell backwards hitting her tailbone and her back on the snow.

Claimant testified that within ten minutes of the fall she made her way to the lieutenant's office and reported that she had injured her back in the fall. Claimant continued to work after reporting her accident. She did not ask for medical treatment at the time. By that evening claimant began to notice problems. Claimant testified that she is into natural medicine and sees a chiropractor for general health issues. She first sought treatment with her chiropractor, William Hafner, D.C. She complained of neck pain, mid back pain and aching and burning. Claimant took sick leave December 12-14, 2009. Claimant couldn't recall when she requested medical attention, but when she did, she was referred to Mark Ethan Van Norden, D.O.

Claimant was first referred by respondent to Dr. Van Norden on October 20, 2009, with complaints of back pain, with most of her discomfort in the mid-thoracic spine, but also with pain in the upper and lower back. Claimant reported that her pain occurred at work on October 5, 2009, while she was using a twisting motion to lift a heavy legal paper sized box from overhead. Claimant complained of constant burning low back pain, some mid-thoracic spine pain, and upper lumbar and upper thoracic pain. Claimant reported that, although her pain was 50 percent better at this visit, the pain was worse when she stood for too long or if she raised her leg or bent down. Dr. Van Norden examined claimant and opined she had a lumbar spine strain and thoracic strain and instructed her to continue with the chiropractic care she had been receiving. Claimant was returned to work without restrictions.

Claimant was next examined on December 17, 2009, with thoracic spine pain, similar to that at her prior visit. Claimant described the pain as worse with rotation to the right and with flexion of the spine and worse when she sat in one position for too long. Claimant reported that this pain was due to falling in the snow while performing a security check at work. Claimant had been to the chiropractor a few times before coming in to see Dr. Van Norden. Dr. Van Norden diagnosed a thoracic spine strain and recommended claimant be treated conservatively with medication. He also provided restrictions limiting her lifting and carrying, and recommended frequent position changes. Claimant was to walk around as needed and to limit contact with the inmates.

Claimant returned to Dr. Van Norden on December 24, 2009, after two sessions of physical therapy. She presented with continued back pain and new complaints of numbness and tingling around the scapula bilaterally, shooting pain in her left chest, shoulder pain more posterior than lateral, and her left hand would fall asleep at night. Dr. Van Norden diagnosed low back pain and AC joint strain. Claimant was instructed to continue with her medication and physical therapy.

Dr. Van Norden met with claimant again on January 7, 2010, for followup. Claimant had complaints of pain in the thoracic and lumbar spine, and the left shoulder. This complaint of shoulder pain was new, and was not reported during the initial visit for this injury. Dr. Van Norden noted that, even though physical therapy reported claimant had full range of motion and been successfully treated, claimant continued to have pain symptoms and reported abdominal muscle weakness. Claimant wasn't working because she was not physically able.

Dr. Van Norden diagnosed continued AC joint strain and documented low back pain, specifically thoracic spine pain. Dr. Van Norden could find no reason for claimant's lack of improvement, but indicated that her inactivity at home was a contributing factor. He advised claimant to find some light activity to do around the house, instead of laying around all day. Dr. Van Norden referred claimant to Dr. Poole for evaluation.

Dr. Van Norden last saw claimant on March 11, 2010, for the same pain complaints. He continued to diagnose claimant with thoracic spine strain and AC joint strain. Dr. Van Norden opined that claimant's complaints were consistent with the two occasions when claimant reported accidents at work, and could have been caused by either or both incidents. Claimant's final restrictions were no lifting greater than 20 pounds, minimal use of the right arm, no stooping, bending, and limited inmate contact.

Claimant first met with orthopedic surgeon Bernard T. Poole, M.D., on January 21, 2010, for an examination of claimant's cervical, dorsal and lumbar spines and upper and lower extremities. Claimant's history included injuries to her neck, between shoulders and middle and low back on December 11, 2009, while doing fence work in deep snow at the correctional facility. A clinical exam of the cranial nerves showed no focal abnormality. The cervical spine exam identified no guarding, no spasms, normal contour and no

localized tenderness with a full range of motion. X-rays of the cervical spine were essentially normal, without evidence of degenerative disc and facet joint disease and no evidence of instability at any level. The examination of claimant's upper limbs showed a full range of movement in the shoulders, elbows, wrists and hands. Deep tendon reflexes were normal. Power in the upper extremities was normal with excellent grip strength bilaterally.

The examination of the dorsal spine was normal with no muscle guarding or spasm and no localized tenderness in the scapular or paravertebral muscles. X-ray examination of the thoracic spine was normal. The examination of the lumbar spine elicited tenderness on the left side at L4-S1. However, there was a full range of flexion, extension, rotation and lateral bending. Claimant walked normally, did the toe/heel exam without difficulty and had a negative Babinski sign. Deep tendon reflexes were normal at the knees and ankles with no muscle wasting or weakness in either lower extremity. The physical examination of the lumbar spine was completely normal, although x-rays did show a degree of degenerative arthritic change in the left sacroiliac joint when compared to the right.

Dr. Poole opined that claimant had a simple strain injury to her back on at least two occasions and the only clinical examination which was abnormal at the time of the examination was pain on compression and stress of the left sacroiliac joint. Dr. Poole felt claimant was fit to return to work with a restriction limiting her bending and lifting to 25 pounds. In addition to continuing with medication, Dr. Poole felt claimant would benefit from physical therapy with heat, ultrasound and McKenzie exercises to the low back.

On February 16, 2010, following two weeks of physical therapy, claimant returned to Dr. Poole. Claimant reported the physical therapy did not work and described her pain as an 8 out of 10. Claimant's pain was present in her entire spine. However, she indicated digitially that the pain was present from T12 down to her sacroiliac joint, involving the entire lumbar spine on both sides. Claimant also reported occasional pain in her upper back and neck.

Dr. Poole could find no convincing evidence that claimant had significant pathology present which would preclude her from returning to regular work. As a precaution, he recommended she limit frequent or repetitive lifting to less than 100 pounds. He did not feel that claimant had any permanent impairment. Claimant was released to regular duty on February 17, 2010.

Claimant was eventually referred by Dr. Poole to physical medicine and rehabilitation specialist John G. Fan, M.D. Claimant first met with Dr. John Fan on March 12, 2010, with complaints of severe low back pain and left sided back pain related to a fall work on December 11, 2009.

Dr. Fan opined that, based on claimant's history and her complaints, she had low back pain after the injury at work on December 11, 2009; left side L5 distribution

radiculopathy; severe functional impairment; and obesity. Dr. Fan testified that severe functional impairment means claimant cannot take care of herself when it comes to bending over, lifting, or doing house chores. He recommended claimant have an MRI of the lumbar spine. He also found claimant unable to work.

Claimant underwent an MRI on March 22, 2010, which was read as normal. She returned to Dr. Fan on March 26, 2010. Claimant continued to have mild tenderness to palpation in the lumbar spine, limited range of motion, and left side L5 radiculopathy. A nerve block injection was recommended. Claimant was encouraged to continue in a lumbar spine stabilization exercise program. Claimant had a nerve block injection on April 23, 2010.

Claimant was next seen on May 21, 2010. Claimant expressed difficulty after returning to work and complained of an increase in back pain, with muscle spasm. A series of injections for sciatic pain was recommended. Dr. Fan provided two cortisone injections on the left side of claimant's spine. These injections provided two weeks of relief.

Claimant was seen again on June 4, 2010, with continued diffuse tenderness to palpation and limited range of motion. Dr. Fan recommended claimant have a functional capacity evaluation (FCE), which was conducted on August 12, 2010. Dr. Fan did not see claimant again until August 17, 2010, at which time he did a detailed review of claimant's FCE results. The FCE showed claimant had a 0 percent whole body impairment of the lumbar spine. The evaluation suggested claimant gave very poor effort and no restrictions were recommended. At this August 17th visit, claimant continued to report pain, which she rated at a 6 out of 10, but she reported enough improvement that she had been able to wash dishes and do some vacuuming. Claimant had also lost 10 pounds. Claimant was released to full duty.

On September 6, 2010, Dr. Fan found claimant to be at maximum medical improvement. She was referred to a psychiatrist to rule out malingering due to her poor effort during the FCE. Claimant's opiate prescription was also stopped to avoid addiction and dependency.

Claimant was next seen by Dr. Fan on November 12, 2010. She reported that her back pain was the same and that she was no longer working for respondent. Claimant was working as a substitute teacher and planning on going to nursing school. Upon examination, claimant continued to have tenderness and limited range of motion in the lumbar spine. Claimant was encouraged to continue with weight loss and spine stabilization.

On February 11, 2011, claimant's condition continued to be the same and Dr. Fan imposed temporary work restrictions. Claimant was seen again on June 3, 2011, with no major change in her condition. Claimant was instructed to continue with her pain

medication and exercises. Claimant called on September 21, 2011, seeking a refill on her pain medication. Claimant was to periodically check in because of the narcotic medication prescribed to her.

On December 2, 2011, she was seen by Dr. Fan again, reporting that she had lost her job and was trying to obtain her college degree. Claimant was asked to return in three months. She returned on April 4, 2012, at which time she continued to have the same symptoms and was instructed to continue with weight loss and spine stabilization.

Dr. Fan's final diagnosis was chronic low back pain, radiculopathy and claimant's weight problem. He did not feel claimant was in need of permanent restrictions and recommended claimant return to work. He went on to opine that under the 4th edition of the AMA *Guides*[1], claimant would have somewhere between a 0 and 5 percent permanent functional impairment.

At the request of her attorney, claimant met with board certified physical medicine and rehabilitation specialist George G. Fluter, M.D., for an examination on June 8, 2011. Claimant complained of pain in her upper back, mid-back, lower back and pain in her left thigh and foot. She described the pain as aching, shooting and burning. Claimant reported being confined to bed at least once a week because of the pain.

Dr. Fluter diagnosed claimant with status post work-related injury on December 11, 2009; low back/left lower extremity pain; lumbsacral strain/sprain; probable left lower extremity radiculitis; myofascial pain affecting the lower back; probable sacroiliac joint dysfunction; and probable left trochanteric bursitis. Dr. Fluter assigned claimant a 10 percent permanent partial functional impairment to the body as a whole. He opined that there is a causal/contributory relationship between claimant's current condition and the reported injury of December 11, 2009.

Dr. Fluter recommended restrictions of limited lifting, carrying, pushing and pulling up to 35 pounds occasionally and 15 pounds frequently, restricted bending, stooping, crouching and twisting to an occasional basis and restricted squatting, kneeling, crawling and climbing to an occasional basis. He had no further diagnostic or therapeutic recommendations.

Claimant was referred by the ALJ to Michael J. Johnson, M.D., a board certified orthopedic surgeon, for a court-ordered IME on September 20, 2011. Claimant's chief complaint was low back pain, and pain in the posterior hips. There was also evidence of thoracic pain. Dr. Johnson noted claimant had a history of low back pain from an incident on October 13, 2009, for which treatment was provided. That pain resolved. Claimant reported no low back pain at the time of the December 11, 2009, accident.

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[1] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment*.

Dr. Johnson reviewed an FCE performed on August 12, 2010, by Mark Schukman, Pt., at Advanced Therapy & Sports Medicine. Claimant's FCE documented "'symptoms/disability exaggeration behavior'". Claimant passed only 54% of the written criteria indicating "poor effort or voluntary submaximal effort which in [sic] is not necessarily related to pain, impairment or disability. She did exhibit many functional limitations in all tasks tested. Restrictions were recommended with her Lumbar range of motion measurement were considered "'invalid'".[2]

Dr. Johnson conducted his examination and opined that claimant did not express any instances of increased symptoms and/or pain above normal baseline symptoms, and no additional distress after the exam. He found claimant to have chronic low back pain/strain. Dr. Johnson found that the chronic low back pain/strain was the only injury specifically from December 11, 2009. However, he went on to note claimant displayed only minimal objective findings and no evidence of structural change from the x-rays and MRI performed. Claimant's subjective complaints outweighed her objective findings.

Dr. Johnson noted claimant's left sacroiliac iliac pain and left hip greater trochanteric bursitis were not evident until June 8, 2011. Dr. Johnson also noted the examination by Dr. Fluter which identified hip, SI, sensory changes and calf atrophy not previously seen by Dr. Van Norden, Dr. Poole or Dr. Stein.[3] He determined those findings were not related to the work injury on December 11, 2009. Dr. Johnson assigned a 5 percent whole person impairment for the back pain. He felt claimant could return to full duty without restrictions.

Claimant has not worked for respondent since September 11, 2010, when her employment was terminated due to attendance issues. After claimant's employment with respondent was terminated, she applied for unemployment, despite the fact that she testified she is unable to sit or stand for long without pain. Claimant was denied unemployment compensation. She has pain in the middle and left side of her back which radiates down into her buttocks and her left leg at the thigh. Claimant did find work as a substitute teacher for a short period from March to May 2011. After that, she didn't renew her license to teach, due to the yearly renewal cost.

Claimant's current complaints include pain mainly in the lower back, above the waist and below the waist band, down into her buttocks, down her left hip and into her left leg. She feels pressure on her spine all of the time. She sometimes has pain in her neck. Claimant believes her pain is from the fall on December 11, 2009.

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[2] Johnson Depo., Ex, 2 at 3-4.

[3] Dr. Stein examined claimant on December 26, 2010, at the request of her attorney, but neither that medical report, nor the testimony of Dr. Stein is contained in this record.

Claimant was examined by vocational specialist Steven Benjamin on May 29, 2012. Mr. Benjamin compiled a list of jobs and related job tasks for the fifteen years preceding claimant's date of accident. He determined that, based on the work restrictions of Dr. Fan, Dr. Stein and Dr. Johnson, claimant would be able to return to her job with respondent without limitation and would be able to work in a similar position and earn a comparable wage. However, no physician utilized the task list created by Mr. Benjamin to determine what, if any, task loss claimant may have suffered as the result of her work-related accident. As noted by the ALJ, there is no evidence of a task loss in this record.

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[4]

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[5]

Claimant contends she suffered permanent injuries as the result of the fall on December 11, 2009. There is very little objective evidence of permanent injury to claimant in this record. Dr. Fluter's opinion is based almost entirely on subjective complaints. What objective findings he did utilize are contradicted by the findings of Dr. Fan and Dr. Poole. Additionally, claimant's credibility is severely eroded by the FCE which indicated multiple attempts by claimant to adversely alter the FCE findings. Dr. Fan stated the FCE suggested a very poor effort by claimant.

Dr. Johnson noted the FCE findings indicating claimant passed only 54% of the written criteria indicating "poor effort or voluntary submaximal effort which in [sic] is not necessarily related to pain, impairment or disability." Dr. Poole testified that claimant had sustained no organic permanent impairment.

K.S.A. 44-510e(a) defines functional impairment as:

> . . . the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

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[4] K.S.A. 2009 Supp. 44-501 and K.S.A. 2009 Supp. 44-508(g).

[5] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

The Board finds claimant has failed to prove that she suffered permanent injury as the result of the accident on December 11, 2009. This record supports a finding that claimant suffered an accident on that date, but any resulting permanent injuries are not supported by this medical record. The Board agrees with the ALJ's finding that claimant appeared less than forthright in her presentation. The Board finds claimant has not satisfied her burden of proving that she suffered permanent impairment from this accident.

K.S.A. 44-510e states in part:.

> The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury.

There is no task loss opinion in this record. The Board has previously determined that the lack of permanent impairment, coupled with the lack of a task loss, results in a finding of no permanent partial general disability. In *Blaskowski*[6], the Board determined that the claimant had failed to prove that he suffered permanent impairment or permanent disability. Claimant's award of permanent disability by the ALJ was reversed. Likewise in *Abdi*,[7] the Board was asked this same question. The Board, in *Abdi*, concluded that the claimant suffered no permanent impairment and no work disability. This finding was affirmed by the Kansas Court of Appeals after finding that *Abdi*, who had passed a pre-employment physical with another meat plant, shortly after leaving Tyson, failed to prove permanent impairment or disability. The Court found *Abdi* to not be credible.

The Board also finds this claimant to lack credibility. Her symptoms appeared to multiply as time passed. She failed to provide a credible effort during the FCE. And, most, if not all, of her impairment was based upon her subjective symptoms, with little to support an actual permanent impairment. The award of permanent benefits in this matter by the ALJ is reversed. The award of TTD and past and unauthorized medical treatment remains in full force and effect.

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[6] *Blaskowski v. Cheney Door Company*, No. 1,051,744, 2011 WL 4961957 (WCAB Sept. 28, 2011), aff'd No. 106,899, 286 P.3d 239 (Kansas court of Appeals unpublished opinion filed Oct. 5, 2012).

[7] *Abdi v. Tyson Fresh Meats, Inc.*, No. 104,132, 256 P.3d 897, (Kansas Court of Appeals unpublished opinion, filed Aug. 5, 2011).

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be reversed with regard to an award of permanent impairment and disability. Claimant has failed to prove that she suffered a permanent functional impairment or permanent partial disability stemming from the accident on December 11, 2009. The award of temporary benefits, including TTD and past and unauthorized medical treatment is affirmed.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Bruce E. Moore dated December 4, 2012, is affirmed with regard to the award of temporary total disability compensation and past and unauthorized medical treatment, but reversed with regard to a permanent functional impairment or permanent partial general disability.

IT IS SO ORDERED.

Dated this _____ day of April, 2013.

_____
BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: R. Todd King, Attorney for Claimant
trod@kbafirm.com
tking@kbafirm.com

E. L. Lee Kinch, Attorney for Respondent and its Insurance Carrier
elleekinchlaw@gmail.com
kinchel@sbcglobal.net

Bruce E. Moore, Administrative Law Judge